STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555039	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fireside Health Care Center	947 3rd Street Santa Monica, CA 90403

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42342 Based on interview and record review the facility failed to report alleged abuse to the abuse coordinator and state agency for one of three residents sampled residents (Resident 1). This deficient practice placed other residents at risk for potential alleged abuse. Findings: A review of Resident 1 ' s Admission Record indicated the facility admitted the [AGE] year-old male on 7/23/2024 with diagnoses including Hemiplegia affecting the left side (weakness of paralysis of the entire left side of the body), dislocation of left shoulder joint, history of falls, essential hypertension (high blood pressure) and polyneuropathy (many nerves in different parts of the body have pain). A review of Resident 1 ' s Minimum Data Set (MDS-a standardized assessment and care planning tool) dated 8/7/2024, indicated Resident 1 ' s cognition (mental ability to make decisions for daily living) was mildly impaired. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) with toileting, personal hygiene, and transfers (moving between surfaces) from bed to chair. On 8/5/2024 The California Department of Public Health (CDPH) received a complaint alleging Resident 1 was hit by and employee. During an interview on 8/7/2024 at 12:09 p.m., Resident 1 stated on 8/3/2024 the certified nursing assistant (CNA) 1 who delivered Resident 1 ' s breakfast tray tried to hit Resident 1. Resident 1 asked for some butter and CNA 1 allegedly brought the butter and threw the butter onto the tray. Resident 1 was then upset and stated, don ' t throw it show some respect to which CNA 1 replied, don ' t tell me how to do my job after which Resident 1 stated CNA 1 then reached for Resident 1 as if to hit Resident 1. Resident 1 then stated, don ' t touch me. Resident 1 then grabbed the cell phone and threatened to call the police. Resident 1 stated CNA 1 did not hit Resident 1 but Resident 1 felt very angry after the incident. Resident 1 stated an unidentified staff member entered the room and asked what was going on because Resident 1 was arguing with CNA 1. Resident 1 explained what happened to the unidentified staff member and the unidentified staff member stated, CNA 1 would not do that. Resident 1 stated, why would I make that up and told both CNA 1 and the unidentified staff member to exit the room. Resident 1 did not call the police and did not see CNA 1 for the rest of the day. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/7/2024 at 2:10 p.m. with CNA 1, CNA 1 stated on the morning of 8/3/2024, CNA 1 went to Resident 1 ' s room to answer the call light. CNA 1 stated Resident 1 asked for extra butter. CNA 1 went to the kitchen and returned to the room with the butter and placed it on the table and stated, Here is your butter and exited the room. CNA 1 went to attend to another resident them returned to Resident 1 ' s room to answer the call light again. CNA 1 stated upon entering the room Resident 1 began to yell stating, why would you do that and treat me like a dog. CNA 1 stated Resident 1 was accusing CNA 1 of throwing butter at Resident 1 and hitting Resident 1. CNA 1 denied this happened and went to get the Licensed Vocational Nurse (LVN) 1 in charge to come to Resident 1 ' s room. During an interview on 8/7/2024 at 3:53 p.m., the Assistant Director of Nursing (ADON) stated alleged abuse had to be reported immediately to the supervisor on shift and the Administrator (Adm). The ADON further added the ADON had been covering for the DON since 8/5/2024 and was not informed by LVN 1 nor CNA 1 about the alleged incident between CNA 1 and Resident 1 on 8/3/2024. During an interview on 8/7/2024 at 4:22 p.m. with LVN 1, LVN 1 stated on 8/3/2024 CNA 1 asked LVN 1 to go into Resident 1 ' s room because there was a problem; Resident 1 was accusing CNA 1 of things that did not happen. Resident 1 told LVN 1 that CNA 1 threw food at and hit Resident 1. LVN 1 then removed the cover from the breakfast tray and noticed all the food there was untouched. LVN 1 said to Resident 1, maybe Resident 1 was offended by the tone of CNA 1 ' s speech at times but LVN 1 did not believe CNA 1 threw food and hit Resident 1. LVN 1 apologized to Resident 1 for the misunderstanding and reassigned CNA 1. LVN 1 did not interview CNA 1 ' s other residents to inquire about potential abuse. LVN 1 did not report the incident to the abuse coordinator nor to the ADON. LVN 1 stated the incident should have been reported because Resident 1 alleged physical abuse, and the abuse allegation should have been investigated. During an interview on 8/7/2024 at 4:22 p.m. with the Adm, The Adm stated the Adm was the abuse coordinator and allegations of abuse had to be reported to the Adm immediately. The Adm stated neither LVN 1 nor CNA 1 reported the incident between CNA 1 and Resident 1 on 8/3/2024 until the interview with the surveyor on 8/7/2024. The Adm stated LVN 1 absolutely should have reported the incident to the Adm immediately, so the Adm could then reported the incident to the ombudsman and police; investigated and submitted the 5 days conclusion to CDPH. A review of the facility policy and procedure titled, Abuse Prevention and Prohibition Program dated 10/2022 indicated, IX. Reporting/Response A. Facility Staff are Mandatory Reporters i. Facility owners, operc1tors, employees, managers, agents, and contractors are obligated by the Elder Justice Act and the California Elder Abuse and Dependent Adult Civil Protection Act to report known or suspected instances of abuse of elder or dependent adults. ii. The Facility will not impede or inhibit a Facility Staff member's reporting duties, nor will Facility Staff be reprimanded or disciplined for reporting abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	iii. The Facility has a strict non-retaliation policy for good faith reporting in compliance with the Elder Justice Act and the Elder Abuse and Dependent Adult Civil Protection Act. iv. Failure to report suspected or known abuse may result in legal action against the individual(s) withholding such information. Administrator, or his/her designee, as Abuse Coordinator i. In order to facilitate reporting, ensure confidentiality, and promote order at the Facility, the Administrator, or his/her designee, shall be the individual who reports known or suspected instances of abuse of residents at the Facility to the proper authorities. ii. Facility Staff will report known or suspected instances of abuse to the Administrator, or his/her designee. iii. Facility/staff members shall be notified that the Administrator, or his/her designee, has this responsibility, and that inquiries concerning resident abuse and reporting requirements should be referred to the Administrator, or his/her designee.